

WISCONSIN MEDICAID
PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) EXEMPTION REQUEST

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request Completion Instructions (HCF 11075A).

Dispensing providers must have a completed PA/PDL Exemption Request signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request.

SECTION I — RECIPIENT INFORMATION	
1. Name — Recipient (Last, First, Middle Initial)	2. Date of Birth — Recipient
3. Recipient Medicaid Identification Number	
SECTION II — PRESCRIPTION INFORMATION	
4. Drug Name	5. Strength
6. Date Prescription Written	7. Directions for Use
8. Diagnosis — Primary Code and/or Description	
9. Name — Prescriber	10. Drug Enforcement Agency Number
11. Address — Prescriber (City, State, Zip Code)	
12. Telephone Number — Prescriber	
SECTION III — CLINICAL INFORMATION	
13. Has the recipient experienced treatment failure with the preferred product(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, list the preferred drugs that failed and the dates taken below:	
14. Does the recipient have a condition(s) preventing the use of the preferred product(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, list the conditions below:	
15. Is there a clinically significant drug interaction between another medication the recipient is taking and the preferred product(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, list the medications and interaction(s) below:	
16. Has the recipient experienced intolerable side effects while on the preferred product(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, list the side effects below:	
17. SIGNATURE — Prescriber	18. Date Signed

Continued

SECTION IV — FOR DISPENSING PROVIDERS USING STAT-PA		
19. National Drug Code (11 digits)		20. Days' Supply Requested*
21. Wisconsin Medicaid Provider Identification Number (Eight digits)		
22. Date of Service (MM/DD/YYYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to four days in the past.)		
23. Place of Service (Patient Location) (Use patient location code "00" [Not specified], "01" [Home], "04" [Long Term/Extended Care], "07" [Skilled Care Facility], or "10" [Outpatient])		
24. Assigned Prior Authorization Number (Seven digits)		
25. Grant Date	26. Expiration Date	27. Number of Days Approved
*Days' supply requested equals the total number of days requested for the PA. For example, for a one-year PA, providers should enter "365."		

SECTION V — ADDITIONAL INFORMATION		
28. Include any additional information in the space below. For example, providers may include that this PA request is being submitted for a recipient who was granted retroactive eligibility by Wisconsin Medicaid, BadgerCare, or SeniorCare.		